PRINTED: 07/14/2011 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES					OM	B NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	G	00	COMPL	ETED
		155070	B. WIN				06/10/2	011
NAME OF I	DROVIDED OD GUDDI IE.	D.	-	STI	REET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	r.		3118 GREEN VALLEY ROAD				
	VALLEY CARE CE					LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREF		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
	REGULATORT OF	CESC IDENTIFTING INFORMATION)	+	IA	u			DATE
F0000								
	This visit was for a Recertification and State Licensure Survey.		FO	0000		This plan of Correction is submitte	ed	
			10	,000		under Federal and State regulatio	ns	
	State Licensure	Survey.				and status applicable to long-term providers. This Plan of Correction		
	Survey dates: J	une 6, 7, 8, 9, 10, 2011				not constitute an admission of liab on the part of the facility and such liability is hereby denied. The	oility	
	Facility number	. 000028				submission of this plan does not		
	Provider numbe					constitute an agreement by the fa- that the surveyors' findings or	cility	
	Aim number: 1					conclusions are accurate, that the		
		00273370		the scope and severity rega		findings constitute a deficiency, or the scope and severity regarding the deficiencies are cited correctly	any of	
	Survey team:					Furthermore, we request this Plan		
	Donna Groan, R					Correction serve as our credible		
	Avona Connell,	RN				allegation of compliance.		
	Gloria Reisert, I	MSW June 6, 8, 9, 10,						
	2011							
	Dorothy Navetta	a, RN June 6, 7, 8, 9, 2011						
	Census bed type): ::						
	SNF/NF: 116							
	Total: 116							
	Census payor ty	pe:						
	Medicare: 10							
	Medicaid: 88							
	Other: 18							
	Total: 116							
	10							
	Sample: 24							
	These deficience	ies also reflect state						
	findings cited in	accordance with 410 IAC						
	16.2.							

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M49M11

Facility ID:

000028

TITLE

If continuation sheet

(X6) DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUI A. BUILE		NSTRUCTION 00	(X3) DATE S COMPL		
		155070	B. WING			06/10/2	011
	PROVIDER OR SUPPLIER VALLEY CARE CEN			STREET A	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD BANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	PREFIX (EACH CORRECTIVE ACCROSS-REFERENCED T		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	-E	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0164 SS=D	Quality review 6/16/ The resident has the and confidentiality clinical records. Personal privacy in medical treatment, communications, pure meetings of family this does not requiprivate room for each except as provided section, the residenthe release of personal and clinic when the resident health care institut required by law. The facility must keinformation contain	/11 by Suzanne Williams, RN the right to personal privacy of his or her personal and ncludes accommodations, written and telephone personal care, visits, and and resident groups, but tre the facility to provide a ach resident. d in paragraph (e)(3) of this nt may approve or refuse sonal and clinical records to		TAG	DEFICIENCY		DATE
	methods, except we transfer to another third party payment Based on record facility failed to emedical informate dialysis binder we confidential for 1	when release is required by healthcare institution; law; at contract; or the resident. review and interview, the ensure personal and ion contained in the as kept safe and of 2 dialysis residents apple of 24. (Resident	F01	64	Resident #109's dialysis communication binder was located and returned to facilit the ambulance service on Saturday 6/11/11. Residents who receive dialysis services have the potential to be affect by the alleged deficiency. An audit was completed on 6/28/2011 to ensure that no complete that no complete that the service of the service	s sted other e	07/10/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPLI	ETED
		155070	B. WIN			06/10/20	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	REEN VALLEY ROAD		
GREEN	VALLEY CARE CEN	NTFR		1	LBANY, IN47150		
				L	227 441, 11417 100		27.5
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION DATE
1710	-	ord for Resident #109 was		I/IG	compliance. New facility pro	otocol	DATE
					will be for the Dialysis Center		
	reviewed on 6/8/11 at 1 p.m. The resident's diagnoses included, but were				begin faxing the facility a rep		
					after each visit to ensure		
		nronic kidney disease with			communication between faci	· .	
	1	time of review, the			and center occurs. DON spo with the DON at FMC Dialysi		
	1 *	t locate the blue dialysis			center on 6/28/2011 and to	3	
	1	correspondence with the			Regional Coordinator with Da	avita	
	dialysis center.				Dialysis on 6/29/2011 to notif	fy	
					them of new facility protocol		
	On 6/9/11 at 2:30	0 p.m., the Director of			they agreed to assist and con		
	Nursing indicate	d the blue dialysis book			with request. Don or Desigr will complete weekly audits >		
	was not at the di	alysis center and the EMS			weeks and then monthly to	`	
		dical Service) indicated			ensure Dialysis Center		
		eft in the ambulance on			communication sheets are		
	the stretcher.				received and filed	.	
					appropriately. Results from to audits will be reviewed montl		
	On 6/10/11 at 9 :	a.m., the Assistant			the PI Committee Meeting fo	- 1	
		ing provided the dialysis			minimum of one year to ensu		
		ch was faxed on 6/9/11 at			100% compliance. System w		
					updated as indicated. After 1		
	_	he [named] dialysis			if 100% compliance has not l achieved, the PI observation		
		rmation was for treatment			continue to be conducted mo		
		(ay 26, 2011 thru June 9,			and reviewed until 100%		
	1	nysician Orders, dated			compliance has been achiev	ed.	
		he resident was receiving					
	dialysis three tin	nes a week since 1/30/11.					
	1	n the Director of Nursing					
		35 a.m., he indicated the					
	information fron	n the dialysis center was					
	sent yesterday evening at the facility request. He wanted the last two weeks, as the dialysis center nor the EMS could find						
	1	e binder. He wanted to					
		er. Hours have been					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		(X2) MULT A. BUILDI B. WING		NSTRUCTION 00	(X3) DATE S COMPL 06/10/2	ETED	
	PROVIDER OR SUPPLIER		5	3118 GF	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD BANY, IN47150		
	SUMMARY S (EACH DEFICIEN REGULATORY OR Spent trying to lo On 6/06/11 at 10 Admission Packet packet contained Rights which inclimited to "The repersonal privacy or her personal a On 6/10/11 at 12 Administrator pr procedure for "N Practices" dated but was not limit Information Righ The Facility is reprivacy of your h On 6/10/11 at 1:4 Administrator inclination of the privacy of your h Con 6/10/11 at 1:4 Administrator inclination of the blue confidential information Resident #109 ar dialysis center, w	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) cate the book. a.m., the Facility et was reviewed. The a copy of the Residents luded, but was not esident has the right to and confidentiality of his nd clinical records." :35 p.m., the ovided the policy and otice of Privacy 12/29/08 which included, ed to "Your Health hts. Our Responsibilities. quired to: maintain the health information." 45 p.m., the dicated neither the or the ambulance service he binder containing rmation related to his treatment at the which was a binder between the	PR			TE	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155070 06/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY ROAD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE The facility must provide medically-related F0250 social services to attain or maintain the SS=D highest practicable physical, mental, and psychosocial well-being of each resident. The professional cleaning dental F0250 07/10/2011 Based on record review and interview, the recommendation for Resident facility failed to ensure medically related #44 has been reviewed. The social services were provided for 1 of 1 Resident's responsible resident reviewed for dental services in a party/daughter has provided written documentation that she sample of 24. (Resident #44) was and is aware of this recommendation. Findings include: Resident attended an appointment at Dr. Hartman's The clinical record for Resident #44 was Office on 6/30/11 at 11 am. Transportation was provided by reviewed on 6/7/11 at 3:25 p.m. A consult Mission dentist note dated 08/20/10 included, but Transportation. Residents was not limited to "Nothing hurting or receiving contracted in-house dental services have the potential bothering patient at this time. Eating just to be affected. An audit of fine. Patient has several (sic) teeth that residents currently residing in the are present. Dr. [named] highly facility that receive contracted recommends a professional cleaning at dental services was completed on 6/28/2011. The audit reviewed our office. A letter was sent to patient's any recommendations for resp. (responsible) party to see if this can additional outside dental be arranged." A hand written note on the consultations (i.e. oral surgeon form indicated "9/27/10 [named daughter] referrals) during the past 90 will take her after Oct. 15th. Dtr days. The audit revealed there were no outside dental referrals (Daughter) to make appt. (appointment)." that had not been followed-up on. Social Services staff and a In interview with Social Worker #2 on representative from nursing will 6/9/11 at 2:10 p.m., she indicated it was be assigned to round with the dental physician(s) during her responsibility to follow-up with the in-house consultations to ensure daughter to ensure the dental appointment that new orders or was made. Documentation was lacking in recommendations are received. the Social Service notes of any follow-up documented and processed. Social Services staff since 9/27/10. was in-serviced on 6/24/11 by

Facility ID:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		(X2) MU A. BUII		oo	(X3) DATE S	ETED		
		155070	B. WIN			06/10/20	011	
NAME OF PROVIDER GREEN VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150					
· ·	CH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE	
provide the Direction include Function design the me needs of corpor #5 Mu and time assist reducate	ed a copy of rector of Social served dically-release, and direct the able nely; Bull-resident an ion, finance with comments of the comments of	2 p.m., the Administrator of the Job Description for ocial Services which is not limited to "Essential to the Hamiltonian of the Job Description for ocial Services which is not limited to "Essential to the Hamiltonian of the Hamiltonian of the Hamiltonian of the Job Description of the Job Descript			Lacy Beyl & Co. on case management to ensure medirelated social services are provided. New orders related dental referrals requiring additional outside referral services will be reviewed in the Monday-Friday department homeeting. The orders will then taken to the Monday-Friday clinical meeting to ensure the resident's care plan is update indicated. Don, SSD or designial audit new telephone ordereceived dental consultations weekly x 4 weeks, and then monthly to ensure orders have been processed additional outside referrals have been obtained or scheduled, and the care plans have been updated as indicated. Resulf from the audits will be review monthly at the PI committee meeting for a minimum of 1 yto ensure 100% compliance. Systems will be updated as indicated. After 1 year, if 100 compliance has not been achieved, the PI observations continue to be conducted and reviewed at the PI Committee meeting until 100% complian has been achieved.	the ead as gnee ers are we hat the ed as gnee ers are we hat the ed as ed are are we hat the ed are are we are are we are are we are are are are are are are are are ar		
SS=E mainter a sanita	nance servi ary, orderly,	rovide housekeeping and ces necessary to maintain and comfortable interior.	EA	253	Areas identified during the su	ILVOV	07/10/2011	
intervi furnitu	ew, the fac ere, window	ation, record review and cility failed to ensure v sills, over the bed lights a good repair. The	F0	233	were cleaned and or repaired Residents have the potential be affected by the deficient practice. Resident rooms and	d. All to	07/10/2011	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		ĺ	ULTIPLE CC LDING	ONSTRUCTION 00	(X3) DATE COMPI 06/10/2	ETED	
		195070	B. WIN			00/10/2	011
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD		
	VALLEY CARE CE			<u> </u>	LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	IATE	COMPLETION
TAG	ŧ	R LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	1 *	e affected 4 of 21 rooms			common areas were cleaned/dusted with repairs	e made	
	•	2 of 18 rooms on 100			on or prior to 6/24/2011. T		
	hall; and 2 of 4	dining areas and 1 of 1			Environmental Services		
	lobby. These de	eficient practices had the			Director inserviced ES staf	on	
	potential to effect	ct 61 residents who			6/24/2011 regarding expec		
	resided on the 1	00, 200, 300 and 600 halls			cleaning duties and schedu		
	of 116 residents	in the facility.			New Environmental Servi staff will be trained on clea		
		-			schedules duties and sche		
	Findings include	à·			during orientation. Re-educ		
					will be provided by the		
	On 06/06/11 at 7:53 a.m. the following				Environmental Services Di		
	was observed:				or designee for any occurre		
					on non-compliance noted. Environmental Services Di		
	1 The 1 Co.				or designee will audit two	CCIOI	
		ames of 13 of 13 chairs in			Resident Rooms on each u	nit	
	_	room were soiled with			daily Monday-Friday X 4 w	eeks	
	1 *	t that rolled up when			then monthly to ensure roo		
	swiped with the	finger. The wood table			clean and in good repair. Ir		
	with the Prayer	box had heavy dust on the			addition, the common area dining rooms will be audite		
	bottom wood pie	ece.			to ensure they are clean ar	•	
					good repair. Environment		
	2. The wood fra	ames of 24 of 24 chairs in			services audits will be revie	ewed	
	the 600 hall lour	nge/dining area were			monthly at the PI Committe		
	covered.	- •			Meeting for a minimum of	•	
	soiled with heavy d	lust that rolled up when swiped			to ensure the facility is clear in good repair. Systems will		
	with the hand.	•			updated as indicated. If after		
					year, 100% Compliance ha		
	1	of 12:38 p.m. and 1:15 p.m. the			been achieved, PI observa		
	following was obse	erved:			will continue to be conducted		
	3 In the main lobb	by the wood frames of 6 chairs,			monthly and reviewed at the		
		edestal was soiled with heavy			monthly PI committee mee until 100% compliance has		
	dust.				achieved.	20011	
		o over bed lights were soiled					
		d two screws were protruding					
	from the wall appro	eximately 1/4 inch on the wall					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Ì		INSTRUCTION 00	(X3) DATE S COMPL	
		155070	A. BUI B. WIN	LDING IG		06/10/2	
NAME OF P	ROVIDER OR SUPPLIER		P		ADDRESS, CITY, STATE, ZIP CODE		
					REEN VALLEY ROAD		
	VALLEY CARE CEN			L	LBANY, IN47150		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	` `	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	by the hand sink.						
	5. Room 320 The soiled with dust and a slimy substance. The cleaning schedu "Floor Tech" was presupervisor on 06/09/rooms and common time he indicated the daily basis. The "Room Cleaning following: Number heads, vents and all closets, work your wfurniture from top to the "Floor Tech" soil between 7:45 a.m. at and officesvacuum Between 9:00 a.m. a	frames of both beds were one bed frame was soiled with alle for "Resident Rooms" and ovided by the Housekeeping 11 at 10:15 a.m. for resident areas. In interview at this e cleaning was to be done on a g " schedule indicated the 2. "High dust, sprinkler high areas including tops of vay downward, get beds and all bottom" hedule indicated that daily and 9:00 a.m. and Clean lobby an empty trash, dust" und 9:30 a.m." Clean main own chairs, and all horizontal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		(X2) MULTIP A. BUILDING B. WING		STRUCTION 00	(X3) DATE S COMPL 06/10/2	ETED	
	PROVIDER OR SUPPLIER		31	18 GRI	DRESS, CITY, STATE, ZIP CODE EEN VALLEY ROAD BANY, IN47150		
	SUMMARY S (EACH DEFICIEN REGULATORY OR The facility must of periodically a come standardized reproduced resident's fur A facility must make assessment of a respective patterns and communication; Vision; Mood and behavior Psychosocial well-physical functionir Continence;	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) onduct initially and prehensive, accurate, ducible assessment of nctional capacity. As a comprehensive resident's needs, using the restate. The assessment rest the following: demographic information; rest; restrictions; restrictions; restrictions and health conditions; restrictions are restricted.	31	18 GRI W ALE	EEN VALLEY ROAD	E	(X5) COMPLETION DATE
	Discharge potential Documentation of regarding the additional performed through protocols; and Documentation of Based on record facility failed to was declining was 2 residents review	summary information tional assessment the resident assessment participation in assessment review and interview, the ensure a resident who as assessed timely for 1 of wed with a significant ole of 24. (Resident	F0272		Resident # 121 no longer resin the facility. However, no haw as incurred by the resident related to the alleged deficier practice. A 100% audit of the daily 24 hour report sheets wompleted on 6/29/2011 of the past 30 days to assist in identifying any residents who have experienced a change condition. Documentation of assessment(s) completed will	arm nt e iill be ne may of the	07/10/2011

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Event ID:

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If continuation sheet

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	IULTIPLE CO.	NSTRUCTION	COMPL	
ANDILAN	or connection	155070	- 1	LDING	00	06/10/2	
		155076	B. WIN			00/10/2	V 1 1
NAME OF P	ROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GREEN \	VALLEY CARE CEN	ITER		1	REEN VALLEY ROAD _BANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	16	DATE
	The clinical reco	rd for Resident #121 was			reviewed to ensure adequate	e	
	reviewed on 6/8/	11 at 9:22 a.m. The			documentation has been	booto	
	resident's diagno	ses included, but were			completed. 24 hour report s for each unit will be reviewed		
	not limited to Ala	zheimer's and stroke.			daily Mon-Fri during the daily		
	The Nurse's Note	es included, but were not			Dept. Head meeting. Any		
	limited to "3/4/1"	1 2 00 p.m. Resident right			resident(s) identified to have		
	upper arm remain	ns swollen yellow in			experienced a change in the condition will be further revie		
	collor (sic) with	some purple			in the daily Clinical Mtg. to e		
	discoloration not	ed Unit manager and MD			adequate documentation has		
	notified." The no	ext nurse's note was dated			been completed. Licensed		
	"3/6/11 230 p.m.	Placed call to Dr.			nursing staff were re-educate 6/29/2011on the importance		
	[named] office a	bout the swelling in			completing and documenting		
	Residents RUE (Right Upper Extremity).			resident assessments as	,	
	Have been keepi	ng elevated on pillow but			indicated. Newly hired licer		
	still having +2 to	0+3 edema			nursing staff will be trained or importance of completing an		
	(swelling)Arm	's red to yellow to			documenting resident	u	
		Will await MD call and			assessments as indicated. In	ı	
		ue to monitor resident"			addition, licensed nursing		
	Documentation v	was lacking of an			associates will receive re-education on this policy a	nd	
	assessment from	3/4/11 after 2 p.m. until			procedure when completing	iiu	
		m 48 hours passed			annual skill competencies. [OON	
	without an assess	-			or designee will complete a		
		.			random audit weekly x 4 wee		
	In interview with	the Director of Nursing			then monthly of at least 4 me records for resident(s) that n		
		p.m., he indicated there			have experienced a change	-	
		tation between those			their condition to ensure		
	hours.				adequate documentation is t	peing	
	-				completed.		
	3.1-31(a)						
	- (~)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	00	COMPL	ETED
		155070	B. WIN			06/10/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	<u>Į</u>	
NAME OF I	PROVIDER OR SUPPLIEF	t .			REEN VALLEY ROAD		
GREEN '	VALLEY CARE CEN	NTER	NEW ALBANY, IN47150				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
F0323 SS=E	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to ensure hazardous materials and the Hydrocollator (moist heat used in therapy) were secured properly. This deficient practice had the potential to affect 1 of 5 residents who currently resided on the 600 hall and 16 of 25 residents who currently resided on the 100 hall with cognitive impairment, as identified on the current facility resident roster. Findings include:		FO	0323	Hazardous materials (i.e Vir TB, Zephair, Super Sani-Clo and Paraffin) and the hydrocollator packs have be properly secured on 6/6/201 The Good Sense Air Freshe was properly secured on 6/7/2011. Residents with cognitive impairment have the potential to be affected. Further	en 1. ner	07/11/2011
					potential to be affected. Further observation was conducted on 6/6/2011 and 6/7/2011 throughout facility to ensure that potentially harmful chemicals and equipment were secured appropriately. Therapy staff was inserviced on 6/6/2011 and ES staff was in-serviced on		
	1. On 06/06/11 a				6/24/2011 regarding the		
	following chemicals were observed under the sink in the 600 hall/lounge/dining area. A quart of VirexTB (ready to use disinfectant cleaner) and a bottle of Zephair (air freshener). No staff were in attendance. At 8:05 a.m., in interview, the housekeeping supervisor indicated the chemicals were not to be under the sink. 2. On 06/06/11 at 12:25 p.m., the door to the therapy room was standing open. No				importance of adequately securing chemicals and hazardous equipment. On 6/23/2011 a self-closing dev was placed on the door to the therapy room where the hydrocollator and paraffin ar kept. The door will automatic lock when and close. Direct Environmental Services, RS designee will perform randor daily rounds throughout the facility ensuring potentially harmful chemicals and equipmer secured appropriately X weeks then weekly X 4 weel	e cally or of M or m	
staff were in attendance. The following				and monthly X 10 months. Results of the observations			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL		
AND PLAN	OF CORRECTION	155070		LDING	00	06/10/2	
		100070	B. WIN		DDDEGG CITY CTATE ZIR CODE	00/10/2	011
NAME OF	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD		
GREEN	VALLEY CARE CEN	NTER			_BANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	-	TAG		N.	DATE
TAG	Two containers of labeled "Keep or A container of Profession of the Paraffin management of the Paraffi	fety Data Sheet for the ovided by the Director of 8/11 at 9:25 a.m. and for 0:45 a.m. The sheets were 0 a.m., on 06/08/11. The sheets were 10 a.m., on 06/08/11.		TAG	be reviewed at the monthly F meeting. Systems will be upon as indicated. If after 1 year, a compliance has not been achieved, audits will continue a monthly basis.	PI dated 100%	DATE
	1 -	ediately drink one cupful					
	1 -	Get medical attention.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070		LDING	nstruction 00	(X3) DATE S COMPL 06/10/2	ETED	
	PROVIDER OR SUPPLIER		STREET A	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPL TAG DEFICIENCY)		ΓE	(X5) COMPLETION DATE
	the following: Eye contact: In immediately flus water. Remove again. Get medi persists. Ingestion: Do not Never give anyth unconscious persists after The Director of Material Safety Liquid Air Fresh p.m. The sheet witime. First Aid Measur Eye contact: Flushelm plenty of water. medical attention On 06/10/11 at 1 of Nursing provi Safety Sheet for information was First Aid Measur Eyes: Flush eye with plenty of water.	sh eyes with plenty of contact lenses and flush cal attention if irritation of induce vomiting. The provided the sheet for the Good Sense gener on 06/07/11 at 6:06 was reviewed at this same ares were listed as follows: ash immediately with If irritation develops get in. 2:`10 p.m., the Director ded the Material Data Sani-Wipes. The reviewed at this time.				

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CON	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	00	COMPL	ETED
		155070	B. WING	u		06/10/2	011
				REET AI	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			REEN VALLEY ROAD		
GREEN \	VALLEY CARE CEN	NTER			BANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	HE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)	TA	.G	DEFICIENCY)		DATE
	control center im	nmediately. Rinse mouth					
	with water and give affected person one to two glasses of water. Do not attempt						
	vomiting. Never	r give anything to an					
	unconscious pers						
	unconscious per						
	3.1-45(a)(1)						
F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless						
		therapy is necessary to ndition as diagnosed and					
	•	e clinical record; and					
	residents who use gradual dose redu	e antipsychotic drugs receive uctions, and behavioral					
		ess clinically contraindicated, ontinue these drugs.					
		review and interview, the	F0329	,	Upon review of Resident # 20	0's	07/10/2011
		ensure the residents' drug	- 352)		medical record, documentation		, , , , <u> </u>
	•	e from unnecessary			present in Resident # 20's		
	-				medical record from Novemb	er	
	psychotropic, anti-anxiety and hypnotic usage without adequate monitoring and indications for use for 3 of 3 residents reviewed for unnecessary drug usage in a			2010 thru April 2011 in the Psychiatrist's Follow-up			
				Evaluation Sheet and the			
				Pharmacists review sheet that	at		
				validates compliance that the	•		
	sample of 24 res	idents. (Residents #20,			house psychiatrist and the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED	
		155070	B. WIN			06/10/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		\dashv
NAME OF I	PROVIDER OR SUPPLIER				REEN VALLEY ROAD		
CDEENLY	VALLEY CARE OF	ITED					
GREEN	VALLEY CARE CEN	NIER		INEVVA	LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
36, and 104)		Ī		Pharmacy consultant assess			
Findings include:				the resident's need for a GD	I		
				monthly. Additionally, there			
					documentation found in the	notes	
	Review of the cl	inical record for Resident #20			that the resident was		
	on 6/8/2011 at 9:25	a.m., indicated the resident			experiencing any of the abo		
		h included, but were not			noted changes that supports		
		mentia with behavior			change in the resident's trea	itment	
		sive disorder, and psychosis.			plan and that the current		
					medication regimen was		
	The June 2011 mon	thly physician orders signed by			effective. On 5/9/2011, the		
		/2011 indicated the resident			resident experienced some increased drowsiness which	tho	
	was receiving the fo	llowing psychotropic and			Psychiatrist addressed at the		
	anti-anxiety medica	tions:			time to include changes in the		
	- Buspar (for anxiet	y) 10 milligrams [mg] - give 2			resident's medication		
	tablets orally 3 time	s a day - ordered on 5/3/2010.			regimen.Resident # 104's, F	POA	
					is involved in this resident's		
	- Depakote (for psyc	chosis) 125 mg - give 2			on a daily basis for several h	•	
	capsules orally 2 tin	nes a day - ordered on			throughout the day and ever		
	5/3/2010				She is aware and participate	· •	
					the decision process for		
	- Depakote (for dem	entia with behavior			medication changes. In inter	view	
	disturbance) 125 mg	g - give 3 caps orally 2 times a			with the P.O.A., she verifies	that	
	day - ordered on 5/3	/2010.			she requested a GDR not be	e	
					attempted. For residents # 2		
	- Neurontin (for anx	tiety state) 100 mg - give 1			#36, and # 104 documentati	•	
	capsule orally 3 time	es a day - ordered on 5/3/2010			has been added to the medi	cal	
					records supporting the		
	· ·	iety state) 100 mg - give 2			changes/GDR's of the		
	caps orally at bedtin	ne - ordered on 5/3/2010			medications by nursing and		
					services. Residents receivin	~ 1	
		essive disorder) 10 mg - give 1			psychotropic medications ha	•	
	tablet orally once a	day - ordered on 5/3/2010			the potential to be affected by		
					alleged deficient practice.An of residents receiving a	audit	
		xiety) 0.5 mg - give 1/2 tablet			psychotropic medication with	nin	
		- ordered on 5/9/2011 (was 0.5			the last 90 days was comple	•	
	mg - 1/2 tablet 3 tim	nes a day)			on 6/29/2011 to evaluate if t		
					need of a GDR per the facili	•	
		ressive disorder) 15 mg - give 1			policy. The audit revealed th		
	tablet orally at bedti	me - ordered on 5/3/2010			need of a GDR has been		
	L						

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) I			SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:			00	COMPL	ETED
		155070		LDING		06/10/2	011
		100010	B. WIN				
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
				1	REEN VALLEY ROAD		
GREEN '	VALLEY CARE CEN	NTER		NEW A	LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					addressed in regards to resi	dents	
	- Risperadol (for ps	ychosis) 2 mg - give 1 tablet			receiving psychotropic		
	orally every 12 hou	rs - ordered on 5/3/2010			medications. On 6/27/2011tl	ne	
	Review of nursing notes, social service notes and				Director of Nursing spoke w		
					consulting pharmacist to dis	cuss	
	the Behavior Monit	oring Flow records between			expectations of completing		
	11/2010 and 6/2011	failed to locate documentation			required GDR's on psychotr	opic	
	of the resident havin	ng experienced any			medications. Pharmacist		
	behavior/mood issu	es.			understands and agrees to		
					recommendations for GDR's		
	During a medication	n pass observation of Resident			indicated. Staff was in-service		
	#20 on 6/6/2011 at	7:45 a.m. in her room, the			on 6/29/2011 on the importa	nce	
	nurse was observed	having difficulty arousing the			of providing supportive		
	resident and was un	able to give the resident her			documentation for psychotro medication changes and	ppic	
	medications. Obser	vations of the resident on			indications for use. Social		
	6/8/2011 at 10:45 a	.m., on 6/9/2011 at 11:03 a.m.,			Services will review		
	and at 12:15 p.m., o	observed the resident in her			recommendations, and		
	room in her wheelc	hair asleep. The resident did			supporting documentation for	۱r	
	not respond to her r	name being called.			GDR's, behaviors and medic		
	During an interview	with LPN #2 on 6/9/2011 at			changes during the Psychot	•	
	_	cated the resident was wide			Medication Review/ Behavio	ral	
		at breakfast and talking. She			meeting.The DON, SSD or		
		nt was sometimes difficult to			designee(s) will audit new o		
		thought the resident sometimes			received for GDRs weekly x	4	
		she chose whether she wanted			weeks, and then monthly to ensure orders have been		
	to talk to you or not				processed and that care pla	ne	
	lo talk to you of flot	·-			have been updated as indicated		
	During an interview	with LPN #3 on 6/9/2011 at			Results from the audits will be rev		
	_	icated that if the resident was			monthly at the PI committee meet		
		e she was not tired, then she			a minimum of up to 1 year to ensu		
		py during the next day and was			100% compliance. After 1 year, if		
	difficult to arouse.	py during the next day and was			compliance has not been achieve QA observations will continue to be		
	annount to arouse.				conducted monthly and reviewed		
	Review of the 10/2	2/2010 to 5/9/2011 monthly			monthly PI committee meeting un	til	
		ndicated the following: "Staff			100% compliance has been achie		
	1 * *	nood or behavior issues. No			Systems will be updated as indica	ited.	
	_	n, anxiety or yelling out. No					
		or appetite. No apparent					
		on current psychiatric					
	aaverse reaction ne	varione pojemunio					

000028

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	or connection	155070		LDING	00	06/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				REEN VALLEY ROAD		
GREEN	VALLEY CARE CEN	ITER		NEW AI	LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		atrist to see to manage		IAG			DATE
	_	ons and psychiatric diagnosis."					
	During the 5/9/2011 visit, the psychiatrist did indicate the staff informed him the resident was						
		may benefit from reduction in was received to decrease the					
		g three times daily to twice					
	daily.	g					
	2. Review of the cl	inical record for Resident					
		9:45 a.m., indicated the					
	_	ses which included, but were					
	not limited to, advar	nced Alzheimer's and anxiety.					
	Review of the April	2011 monthly physician					
		physician on 4/13/2011					
	indicated the resider	_					
	- Ativan [for anxiety 2 times a day- order	7] 0.5 mg - give 1 tablet orally					
	2 times a day- order	100 011 10/13/2010					
	- Ativan 0.5 mg - gir ordered on 2/24/201	ve 1/2 tablet orally at 5 P M - 1.					
		5 mg - give 1 tablet every					
	night at bedtime - or	rdered on 10/13/2010.					
	Review of the nursing	ng notes between 12/3/2010					
		he Social Service notes					
		and 2/1/2011 failed to locate					
	documentation as to Ativan had been add	why the 2/24/2011 dose of					
	zarvan nau ocen auc	icu.					
	-	with Social Worker #1 on					
	_	m., she indicated the resident					
		s since being moved off the /2011 and did not know why					
	the resident continue						
		gradual dose reductions other					
	than it was the famil	ly's request she be kept on					

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155070	B. WIN			06/10/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			REEN VALLEY ROAD		
GREEN '	VALLEY CARE CEN	NTER			LBANY, IN47150		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	re	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	them.						
	During on intervious	with the DeNi on 6/0/2011 at					
	_	with the DoN on 6/9/2011 at ted it was the family who was					
		to keep the resident on the					
	psychiatric medicat						
	psychiatric inedicat	10115.					
	Review of the nursi	ng notes between 2/24/2010					
		e Social Services' notes					
		nd the Behavior Intervention					
	_	rds between January 2011 and					
	June 2011 failed to	locate documentation of the					
	resident experiencir	ng behavior problems to justify					
	the resident not hav	ing gradual dose reductions.					
		inical record for Resident #36					
		8 a.m., indicated the resident					
	_	h included, but were not					
		with depression and behavior					
	disturbance, parano disorder.	id state, and depressive					
	disorder.						
	On 1/13/2011, the p	sychiatrist reduced the					
	resident's Zyprexa (a psychotropic for behaviors)					
	from 5 mg at bedtin	ne to 2.5 mg as a gradual dose					
	reduction.						
	On 2/10/2011 staff	informed the psychiatrist that					
		king inappropriate sexual					
		e residents and the psychiatrist					
		cation back 5 mg and the					
		enced a failed GDR. On					
	_	hiatrist increased the resident's					
		mg - 1 capsule in the morning					
	to 125 mg - 1 capsu						
		s lacking in the nursing and					
		as to the reasoning for the					
	increase in the med	•					
	During an interview	with Social Worker #2 on					

NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 6/9/2011 at 2:10 p.m., she indicated she had spoken to the resident sometime in February 2011 about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow Records and nursing and social service notes STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150 (X5) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (X5) COMPLETION DATE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		ĺ		INSTRUCTION 00	(X3) DATE : COMPL		
NAME OF PROVIDER OR SUPPLIER GREEN VALLEY CARE CENTER (X4) ID PREFIX TAG (A) EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (B) EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (B) EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (B) PREFIX COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (B) PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE			155070	1		<u></u> -	06/10/2	011
GREEN VALLEY CARE CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL TAG (Figure 1) (Figure 1) (Figure 2) (Figure 2) (Figure 3) (Figure 3) (Figure 3) (Figure 3) (Figure 3) (Figure 4)	NAME OF D	DOWNED OF SUBBLIED		P. ,, 1	_	ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 6/9/2011 at 2:10 p.m., she indicated she had spoken to the resident sometime in February 2011 about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow (X5) COMPLETION DATE					1			
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE AP	GREEN \				NEW AI	LBANY, IN47150		
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE 6/9/2011 at 2:10 p.m., she indicated she had spoken to the resident sometime in February 2011 about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow								
6/9/2011 at 2:10 p.m., she indicated she had spoken to the resident sometime in February 2011 about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow						CROSS-REFERENCED TO THE APPROPRIA	TE	
spoken to the resident sometime in February 2011 about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow	IAG			+	IAG			DATE
about one incident of inappropriate sexual behavior, but indicated she did not investigate as to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow		_						
to whether the resident or someone else was the instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow		about one incident o	of inappropriate sexual					
instigator and what actions were taken. Review of the Monthly Behavior Monitoring Flow		'	_					
Review of the Monthly Behavior Monitoring Flow								
		instigator and what a	actions were taken.					
Pegords and pursing and social service notes		Review of the Mont	hly Behavior Monitoring Flow					
between October 2010 and June 2011 failed to								
locate documentation of the resident having any type of inappropriate behaviors.			C 2					
type of mappropriate behaviors.		type of mappropriate	e deliaviois.					
During an interview with Social Worker #1 on		During an interview	with Social Worker #1 on					
6/8/2011 at 12:24 p.m., she indicated Resident #20		-						
and #36 had a past history of behavior issues, but			istory of behavior issues, but					
nothing current.		nothing current.						
On 6/9/2011 at 8:27 a.m., the DoN presented a		On 6/9/2011 at 8:27	a.m., the DoN presented a					
copy of the facility's current policy on								
"Psychotropic Medication Administration Mental								
Health Referral Consultation". Review of this policy included, but was not limited to, "5. All								
residents currently receiving any psychotropic								
medications will be reviewed to insure that there is								
a diagnosis and documentation to clinically		•	-					
support the appropriate use of the medication12.								
Any resident on psychotropic medications will be reviewed in weekly interdisciplinary meetings"			-					
reviewed in weekly interdisciplinary incettings		leviewed iii weekiy	interdiscipiniary meetings					
The DoN also presented at the same time, a copy		The DoN also presen	nted at the same time, a copy					
of the facility's current policy on "Psychotropic								
Drug Reduction Program". Review of this policy								
included, but was not limited to, "Objective: To evaluate the use of psychotropic drugs (chemical		·						
restraints) in the facility in an effort to consistently								
ensure their appropriate utilization, thus reducing		· ·						
and preventing the use of psychotropic drugs		and preventing the u	ise of psychotropic drugs					
(chemical restraints) whenever possiblePolicy:								
All residents who are currently on any		All residents who ar	e currently on any					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER: 155070	A. BUILDING	00	06/10/2011
		100070	B. WING	ET ADDRESS CITY STATE ZIR CODE	00/10/2011
NAME OF P	ROVIDER OR SUPPLIER			ET ADDRESS, CITY, STATE, ZIP CODE B GREEN VALLEY ROAD	
GREEN V	/ALLEY CARE CEN	ITER	l l	V ALBANY, IN47150	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE
		ation will be evaluated to sity of the drugGoals:1.			
		sible dose be used with every			
	psychotropic drug administration and that each				
psychotropic drug is appropriate for each					
	resident's medical co	ondition"			
	During an interview	with Social Worker #1 on			
	-	n., she indicated that the			
	-	eld weekly, but monthly and			
	-	viewed at these meetings			
		th a change in medications, not			
	everyone.				
	3.1-48(a)(3)				
	3.1-48(a)(4)				
F0411	The facility must a	ssist residents in obtaining			
SS=D	•	ur emergency dental care.			
	A facility result was	vide en eleteia facus en			
	•	vide or obtain from an in accordance with			
	§483.75(h) of this				
	• .	services to meet the needs			
		nay charge a Medicare			
	resident an addition	nal amount for routine and			
	• •	the resident in making			
	appointments; and				
		nd from the dentist's office;			
		residents with lost or			
	damaged dentures	s to a dentist. review and interview, the	F0411	The professional cleaning de	ental 07/10/2011
		follow-up on a dental	1.0411	recommendation for Reside	
	•	for 1 of 1 resident		#44 has been reviewed. The	;
		tal issues in a sample of		Resident's responsible	
	24 residents. (Re	-		party/daughter has provided written documentation that s	
	24 residents. (Re	Siuciil #44)		was and is aware of this	
	Finding includes:			recommendation.	
	i manig metades.	•	<u> </u>		

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		Ì	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/10/20	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	reviewed on 6/7/dentist note date was not limited to bothering patient fine. Patient has present. Dr. [nar a professional cleletter was sent to (responsible) par arranged." A har form indicated "Gwill take her after (Daughter) to match the following to match the following the follo	ty to see if this can be and written note on the 0/27/10 [named daughter]			Resident attended an appointment at Dr. Hartman' Office on 6/30/11 at 11 am. Transportation was provided Mission Transportation. Residents receiving contracted in-hous dental services have the pot to be affected. An audit of residents currently residing i facility that receive contracted dental services was complet 6/28/2011. The audit reviews any recommendations for additional outside dental consultations (i.e. oral surge referrals) during the past 90 days. The audit revealed the were no outside dental referr that had not been followed-uon. Social Services staff and representative from nursing be assigned to round with the dental physician(s) during in-house consultations to en that any new orders or recommendations are received documented and processed. Social Services were in-serviced on 6/24/11 Lacy Beyl & Co. on case management to ensure med related social services are provided. New orders related ental referrals requiring additional outside referral services will be reviewed in the Monday-Friday department is meeting. The orders will ther taken to the Monday-Friday clinical meeting to ensure the resident's care plan is updated.	e ential n the d ed on ed on ere rals p a will e sure red, staff by ically d to the nead n be at the		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		(X2) MULTIPLE CO A. BUILDING	00 	COMPLETED 06/10/2011	
		155070	B. WING	ADDRESS, CITY, STATE, ZIP CODE	06/10/2011
NAME OF P	ROVIDER OR SUPPLIER			REEN VALLEY ROAD	
GREEN \	ALLEY CARE CEN	ITER	NEW AI	LBANY, IN47150	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0428 SS=D	The drug regimen reviewed at least of pharmacist. The pharmacist muto the attending pharmacist, and these upon. Based on record facility failed to expharmacist made gradual dose redumedications for 1 for gradual dose to 24 residents (Resensure there was	of each resident must be once a month by a licensed sysician, and the director of a reports must be acted review and interview, the ensure the consultant recommendations for actions on psychotropic of 3 residents reviewed reductions in a sample of aident #20); and failed to sufficient documentation d for an increase in	F0428	indicated. Don, SSD or desi will audit new telephone ordereceived dental consultations weekly x 4 weeks, and then monthly to ensure orders had been processed additional outside referrals have been obtained or scheduled, and the care plans have been updated as indicated. Resulfrom the audits will be review monthly at the PI committee meeting for a minimum of 1 to ensure 100% compliance. Systems will be updated as indicated. After 1 year, if 100 compliance has not been achieved, the PI observation continue to be conducted an reviewed at the PI Committee meeting until 100% complians has been achieved. Upon review of Resident # 20's medical record, documentati present in Resident # 20's medical record from November 2010 thru April 2011 in the Psychiatrist's Follow-up Evaluation Sheet and the Pharmacists review sheet the validates compliance that the house psychiatrist and the Pharmacy consultant assess	gnee ers s s ve chat ts ved year 0% s will d e nce 07/10/2011 on is per ers cat e c

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l i '		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155070	B. WIN	IG		06/10/2	011
NAME OF I	DROLUDED OD GUDDU IED		-	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3118 G	REEN VALLEY ROAD		
	VALLEY CARE CEN			NEW A	LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	anti-anxiety and	psychotropic medications			monthly. Additionally, there i		
	for 1 of 3 residents reviewed for gradual		documentation found in the			notes	
	dose reductions i	n a sample of 24			that the resident was experiencing any of the above	10	
	residents. (Reside	-			noted changes that supports		
					change in the resident's trea		
	Findings include				plan and that the current		
	Tilldings illetude	•			medication regimen was		
					effective. On 5/9/2011, the		
		e clinical record for			resident was experienced so		
	Resident #20 on	6/8/2011 at 9:25 a.m.,			increased drowsiness which		
	indicated the resi	dent had diagnoses			Psychiatrist addressed at the		
	which included, 1	but were not limited to,			time to include changes in the resident's medication	ie	
	senile dementia v	with behavior			regimen.Resident # 104's, F	O A	
		ressive disorder, and			is involved in this resident's		
	psychosis.	essive disorder, and			on a daily basis for several h		
	psychosis.				throughout the day and ever		
					She is aware and participate	es in	
		onthly physician orders			the decision process for		
	signed by the phy	ysician on 6/1/2011			medication changes. In inter		
	indicated the resi	dent was receiving the			with the P.O.A., she verifies		
	following psycho	otropic and anti-anxiety			she requested a GDR not be attempted. For residents # 2		
	medications:				# 104 documentation has be		
	 - Buspar (for anx	iety) 10 milligrams [mg]			added to the medical record		
	,	rally 3 times a day -			supporting the changes/GDI		
	ordered on 5/3/20	,			the medications by nursing a		
	0146164 011 3/3/20	510.			social services. Residents		
					receiving psychotropic		
		osychosis) 125 mg - give			medications have the potent	ial to	
	1 *	2 times a day - ordered			be affected by the alleged deficient practice. An audit of	•	
	on 5/3/2010				residents receiving a psycho		
					medication within the last 90	•	
	- Depakote (for d	lementia with behavior			was completed to evaluate it	-	
					need of a GDR per the facili		
	disturbance) 125 mg - give 3 caps orally 2 times a day - ordered on 5/3/2010.				policy. The audit revealed th		
	innes a day - ord	CICG 011 3/3/2010.			need of a GDR has been		
					addressed in regards to resi	dents	
	1	anxiety state) 100 mg -			receiving psychotropic		
	give 1 capsule or	ally 3 times a day -			medications. Attempts or		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155070 06/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY ROAD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE completion of a GDR has been ordered on 5/3/2010 completed on residents in which a GDR was not contraindicated. - Neurontin (for anxiety state) 100 mg -This included a review of give 2 caps orally at bedtime - ordered on physician orders for residents 5/3/2010 receiving psychotropic medications has been completed. The audit revealed adequate - Lexapro (for depressive disorder) 10 mg indication for the use of these - give 1 tablet orally once a day - ordered medications is documented in the on 5/3/2010 resident's medical record. Staff was inserviced on 6/27/2011 on the importance of providing - Lorazepam (for anxiety) 0.5 mg - give supportive documentation for 1/2 tablet orally 2 times a day - ordered on psychotropic medication changes 5/9/2011 (was 0.5 mg - 1/2 tablet 3 times and indications for use. Staff was inserviced on 6/27/2011 on the a day) importance of providing documentation of - Remeron (for depressive disorder) 15 non-pharmacological mg - give 1 tablet orally at bedtime interventions prior to administering a PRN (as needed) ordered on 5/3/2010 psychotropic medication and indications for use prior to - Risperadol (for psychosis) 2 mg - give 1 changing hypnotics from PRN to tablet orally every 12 hours - ordered on routine. The facilities policy on completing behavior 5/3/2010 monitoring/interventions was also reviewed. Examples of Review of the consultant pharmacist's appropriate documentation were monthly reports between 11/2010 and provided. Social Services will review recommendations, and May 2011 failed to note any supporting documentation for recommendations from the pharmacist for GDR's, behaviors and medication gradual dose reductions on the resident's changes during the Psychotropic medications. During an interview with the Medication Review/ Behavioral meeting. The DON, SSD or Director of Nursing [DoN] on 6/9/2011 at designee(s) will audit new orders 9:10 a.m., he indicated that if the received for GDRs weekly x 4 pharmacist marked "NI" [no weeks, and then monthly to irregularities], then no recommendations ensure orders have been processed and that care plans were made for gradual dose reductions.

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLETED
		155070	B. WIN			06/10/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CDEENI	VALLEY CARE CEN	ITED			REEN VALLEY ROAD LBANY, IN47150	
					LDANT, IN47 130	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
1710	REGULATORIOR	ESC IDENTIFICATION TO A CONTROL OF THE CONTROL OF T	+	1110	have been updated as indica	
	Review of a 5/10	1/2011 care plan for the			Results from the audits will be revi	ewed
	Review of a 5/10/2011 care plan for the resident being at risk for side effects from				monthly at the PI committee meeti a minimum of up to 1 year to ensu	- 1
		ig use listed one of the			100% compliance. After 1 year, if	100%
		ing "Pharmacy consult			compliance has not been achieved QA observations will continue to be	
	review of medica	-			conducted monthly and reviewed a	• • • • • • • • • • • • • • • • • • •
	leview of illedica	ttion monthly.			monthly PI committee meeting unt	il
	During on interes	iew with the DoN on			100% compliance has been achieved Systems will be updated as indicated	
		50 a.m., he indicated that				
		ith the consultant indicated to him that the				
	_					
	reason she had no	•				
		s for gradual dose				
		ecause the psychiatrist				
	_	rial dose reduction of the				
	^ -	cations listed above,are				
		econdary to risk for				
	exacerbation of:	•				
	• •	chavioral disturbance."				
		vas lacking in the nursing				
		rice notes and behavior				
		records between 10/2010				
		the resident having				
	experienced any	type of behavioral issues.				
	0 (10)0011	11.00				
		11:20 a.m., the DoN				
	1 ^	of the May 17, 2011				
		eduction Tracking Report				
		indicated no dose				
		been attempted since				
	_	of the medications on				
		t none were being				
	planned.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 00	(X3) DATE COMPL		
		155070	B. WIN			06/10/2	011
NAME OF F	PROVIDER OR SUPPLIER	<u>.</u>	<u> </u>	1	ADDRESS, CITY, STATE, ZIP CODE	1	
GREEN \	VALLEY CARE CEN	ITER			REEN VALLEY ROAD LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		e clinical record for					
	Resident #104 on 6/6/2011 at 9:45 a.m.,						
		ident had diagnoses					
		but were not limited to,					
	advanced Alzheir	mer's and anxiety.					
	Review of the Ar	oril 2011 monthly					
	^	signed by the physician					
		licated the resident was					
		[for anxiety] 0.5 mg -					
	_	ly 2 times a day- ordered					
	-	nd Ativan 0.5 mg - given					
		at 5 P M - ordered on					
	2/24/2011.	at 3 F Wi - Ordered on					
	2/24/2011.						
	Review of the nu	irsing notes between					
	12/3/2010 and 2/	24/2011 and the Social					
	Service notes bet	tween 11/12/2010 and					
	2/1/2011 failed to	o locate documentation as					
	to why the 2/24/2	2011 dose of Ativan had					
	been added.						
	Documentation b	•					
	•	also lacking requesting					
		de reasoning as to why					
	the new dosage v	was necessary.					
	Review of a 6/5/	2008 care plan for the					
		risk for adverse effects					
	_	anti-anxiety and hypnotic					
	_	h a review date of					
	•	as one of the approaches					
	· ·						
		ultant to review and make					
	GDR [gradual do	ose reductions]					<u> </u>

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		LDING	NSTRUCTION 00	(X3) DATE COMPI 06/10/2	LETED	
	PROVIDER OR SUPPLIER		 STREET A	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD BANY, IN47150		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) s as indicated."	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	Е	(X5) COMPLETION DATE
	On 6/9/2011 at 8 presented a copy policy on "Psych Administration M Consultation". R included, but was residents current psychotropic mereviewed to insurand documentation the appropriate upharmacy consultant for the propriate upharmacy consultant for the system of the	:27 a.m., the DoN of the facility's current otropic Medication Mental Health Referral eview of this policy s not limited to, "5. All ly receiving any				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		(X2) MULTII A. BUILDIN B. WING		OO	(X3) DATE S COMPL 06/10/2	ETED	
	PROVIDER OR SUPPLIER		31	18 GR	ODRESS, CITY, STATE, ZIP CODE EEN VALLEY ROAD BANY, IN47150		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREI	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION
F0441 SS=D	The facility must el Infection Control F a safe, sanitary ar and to help prever transmission of discontrol for the facility must elegate Program under who (1) Investigates, confections in the facility must elegate program under who (1) Investigates, confections in the facility must elegate program under who (2) Decides what president; and (3) Maintains a recorrective actions (b) Preventing Sprogram (1) When the Infection of Infecti	stablish an Infection Control nich it - ontrols, and prevents cility; orocedures, such as e applied to an individual cord of incidents and related to infections. read of Infection ction Control Program resident needs isolation to d of infection, the facility esident. st prohibit employees with a ease or infected skin contact with residents or contact will transmit the st require staff to wash their direct resident contact for ng is indicated by accepted	TA	.G	DEFICIENCY)		DATE
	transport linens so infection. Based on observe	andle, store, process and as to prevent the spread of ation, record review and willty foiled to appropri	F0441		No harm has occurred to Resident # 12 in regards to tl	ne	07/10/2011
	infection control hand washing we	cility failed to ensure procedures/policies for ere followed for 1 of 2 during 1 of 2 resident			alleged deficient practice. LP 1 re-educated on 6/30/2011 of proper hand-washing technic when performing dressing	N # on	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUI	LDING	00	COMPL	ETED
		155070	B. WIN			06/10/2	011
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	K		3118 GI	REEN VALLEY ROAD		
	VALLEY CARE CE	NTER			LBANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG	+	R LSC IDENTIFYING INFORMATION)	-	TAG		f	DATE
	1	s in the sample of 24.			changes to include guideling the donning and removal of		
	(LPN #1, Reside	ent #12)			gloves. Residents receiving		
					dressing changes have the	,	
	Findings include	e:			potential to be affected by	ne	
					alleged deficient practice.		
	On 6/8/11 between	een 1020 a.m. and 11 a.m.,			Licensed nursing staff wer		
		served gathering supplies			educated on 6/29/2011on p hand-washing technique wh		
		change for Resident #12.			performing dressing change		
		at permission LPN#1			include guidelines for the do		
		ls and donned gloves. As			and removal of gloves. Ne		
		turned to his left side, the			hired licensed nursing staff	will be	
		g Assistant (CNA) who			trained on our policy and		
		` '			procedure for dressing char with emphasis on hand-was		
	1	ted stool in the brief.			and guidelines for the donni		
	1	the opposite side of the			and removal of gloves. In,	9	
		resident over with his			addition licensed nursing		
	1 -	aced on the residents left			associates will receive		
	1 ^	After the resident was			re-education on this policy a		
	cleansed, the CN	NA and LPN #1 switched			procedure when completing annual skill competencies.		
	sides. Without	changing his gloves, LPN			or designee will complete ha		
	#1 poured the no	ormal saline onto the			washing/gloves skills compe		
	gauze and proce	eded to cleanse the area			on 2 nurses from each unit		
	over the coccyx	in a circular motion. He			weekly x 4 weeks and then		
	then changed glo	oves.			monthly. Results from the		
					observations and/ or audits reviewed monthly at the PI	wiii DE	
	On 6/9/11 at 8:3	0 a.m., the Director of			committee meeting for a		
		ed a copy of the Wound			minimum of 1 year to ensure	е	
	1 .	for Major Wounds,			100% compliance. After 1 y		
		04, which included, but			100% compliance has not b		
		to: 6. Explain the			achieved, the QA observation will continue to be conducted		
		resident. 8. Put gloves			monthly and reviewed at the		
	1 ^	· ·			monthly PI committee meet		
	1	clean gloves prior to			until 100% compliance has		
	cleaning the wor				achieved. Systems will be		
		o don clean gloves prior to			updated as indicated.		
	cleansing the wo	ound. In interview with					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155070 06/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 3118 GREEN VALLEY ROAD **GREEN VALLEY CARE CENTER** NEW ALBANY, IN47150 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE the Director of Nursing, at this time, he indicated the nurse should have changed gloves prior to cleansing the wound. 3.1-18(b)(1)The facility must provide or obtain radiology F0508 and other diagnostic services to meet the SS=D needs of its residents. The facility is responsible for the quality and timeliness of the services. Resident # 121 no longer resides Based on record review and interview, the F0508 07/10/2011 in the facility. An audit of x-ray facility failed to obtain an ordered chest orders dating back 90 days was X-ray for 1 of 2 residents reviewed with a completed on 6/28/2011 of the chest X-ray order in a sample of 24. 100 unit to assess for any missed x-ray orders. Orders had been (Resident #121) transcribed and obtained per physician orders. Licensed Findings include: nursing staff was in-serviced on ensuring the transcription and follow-through of X-ray The clinical record for resident #121 was orders.X-ray orders will be reviewed on 6/8/11 at 11:15 a.m. The reviewed in the Monday thru resident's diagnoses included, but were Friday daily department head not limited to Alzheimer and stroke. meeting as well as the daily clinical meeting to ensure adequate follow-up of the orders. Nurse's Notes included, but were not The DON or designee will audit limited to "3/14/11 0950 Resident found new X-ray orders 5x/ week x 4 restless, lung crackles bilaterally, O2 weeks, weekly x 3 months, then (oxygen) 79 % (normal 90 -100), turning monthly to ensure the orders have been transcribed and purple, color on assessment. Oral and processed appropriately. Results nasal suctioning initiated. O2 of 6L from the QA observations will be (liters) /nc (nasal cannula) administered reviewed monthly at the PI per Dr. [named] order. O2 98 % post committee meeting for a minimum of 1 year to ensure administering. CBC (complete blood 100% compliance. After 1 year, if count), BNP (Basic Panel), chest x-ray 100% compliance has not been recommended by DON. Dr. [named] Ok's

FORM CMS-2567(02-99) Previous Versions Obsolete

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If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) I		(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DINC	00	COMPL	ETED
		155070	B. WIN			06/10/2	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			l	REEN VALLEY ROAD		
CDEENI	VALLEY CARE CEN	ITED			LBANY, IN47150		
GREEN	VALLET CARE CEN	TIEN		INEVV AL	LBAN 1, 11147 150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CO		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	mo			DATE
	it. Resident stable after a while."		achieved, the QA observations				
				will continue to be conducted		l	
	On 3/14/11 at 0	950 ((950 a.m.) a			monthly and reviewed at the monthly PI committee meetir	va.	
		was obtained which			until 100% compliance has b		
		s not limited to "chest			achieved. Systems will be	0011	
		." Documentation was			updated as indicated.		
	lacking the chest	x-ray was completed.					
		A a Telephone Order was					
	obtained which is	ndicated "Chest x-ray to					
	R/O (rule out) pr	neumonia and					
	Hyperventilation	P.E. (pulmonary					
	embolus) per Dr.	•					
	onicoras) per 21.	[
	On 6/0/11 at 12:3	30 p.m., in interview with					
		ursing, he indicated he					
		here the X-ray had been					
	ordered.						
	3.1-49(g)						
E0514	The facility must m	naintain clinical records on					
F0514 SS=D	_	ccordance with accepted					
33-0		ards and practices that are					
		ely documented; readily					
		stematically organized.					
		must contain sufficient					
		ntify the resident; a record of					
		essments; the plan of care					
	-	ded; the results of any ening conducted by the					
	State; and progres						
	Ciaio, and progres		1				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155070	B. WIN			06/10/2	011
			1		ADDRESS, CITY, STATE, ZIP CODE	!	
NAME OF I	PROVIDER OR SUPPLIER			3118 G	REEN VALLEY ROAD		
GREEN '	VALLEY CARE CEN	ITFR		I	ALBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG			DATE
	Based on record	review and interview, the	F0	514	The 2011 PASARR Annual		07/10/2011
	facility failed to	ensure the clinical			Resident Review was obtain		
	records were con	nplete and accurately			and reviewed for Residents and #59. All Residents with		
		2 of 3 residents with			MR/DD diagnosis have the	ıan	
		II [Pre-Admission			potential to be affected. The	re are	
		-			currently four Residents with		
	I -	nnual Resident Review]			diagnosis. The Level II pape		
		s for mentally retarded			was reviewed for all four. Or		
	individuals in a s	ample of 24. (Resident			Resident #48 and #59 are		
	#59, #48)				requiring annual reviews. O		
					6/24/11, Social Services Sta		
	Finding includes	-			were in-serviced on PASAR		
	i manig merades	•			Level II reviews by a QMRP		
	1 The clinical reco	rd for Resident #59 was			Lacy Beyl and Company. T	he	
		at 1:25 p.m. The resident's			MR/DD and Level II list was		
		but were not limited to mental			updated to include annual	eff swill	
	_	bral palsy. Review of the			reviews. Social Services standard notify Bureau of Developme		
		08/10 indicated "Has a			Disability Services 60 days p		
		pility and a mental illness;			to required annual review, 3		
		view in one year." The			days prior to required annua		
		determining the resident's			review and weekly therafter		
	current programmin	g and service needs.			the paperwork is received.		
	Documentation was	lacking in the clinical record			Documentation of communic	cation	
	for a PASARR dated	1 2011.			will occur on a telephone log	•	
					in the social services notes i		
		rd for Resident #48 was			medical record. HIM or desi	•	
		at 1 p.m The resident's			will conduct a quarterly audi		
		but were not limited to mental			ensure that the required Lev paperwork is on the chart. A		
		epsy. Review of the PASARR			will be reviewed in the PI	uuits	
		licated" requires resident			committee meeting for a		
		Documentation was lacking			minimum of 1 year to ensure	÷	
	in the record of a ye	arly PASARR for 2011.			100% compliance. After 1 years		
	On 6/7/11 -+ 1.45	ma in intermitary with Carial			100% compliance has not be		
		m., in interview with Social cated the Level II for Resident			achieved, the audits will con		
		of been done. She would call			to be conducted and reviewe	ed at	
	the Agency and chec				the monthly PI committee		
	the rigority and thet	on the status.			meeting until 100% has bee	n	
	On 6/7/11 at 15:35 (3:35 p.m.), she provided a			achieved. Systems will be		
	511 0/ // 11 at 13.33 (5.55 p.m.), one provided a			updated as indicated.		

PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155070			(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/10/2011			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 3118 GREEN VALLEY ROAD NEW ALBANY, IN47150					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	time. The Level II f completed on 3/18/2 Resident #48 was co Social Worker failed to complete the med	II faxed to the facility, at this for Resident #59 was 2011 and the Level II for completed on 4/8/2010. The late obtain the PASARR so as lical record and review it for s to the resident service needs						
	Worker #1, she indic due in April 2011 ar 15:35 (3:35 p.m.) sh II faxed to the facili	m. in interview with Social cated the resident review was ad had not been completed. At the provided a copy of the Level try for Resident #59 and #48. In the stime, she had contacted the						
	3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(2)							
F0516 SS=D	A facility may not resident-identifiable	release information that is le to the public.						
	resident-identifiable accordance with a agent agrees not t	elease information that is le to an agent only in contract under which the o use or disclose the t to the extent the facility o do so.						
	information agains unauthorized use. Based on record facility failed to information and dialysis book wa	afeguard clinical record st loss, destruction, or review and interview, the safeguard clinical record ensure the resident s safeguarded for 1 of 2 s reviewed in a sample of	F0516	Residents who receive dialy services have the potential t affected by the alleged defic An audit was completed on 6/28/2011 to ensure that no residents were affected by the	o be iency.	1		

000028

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155070	B. WIN			06/10/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L			REEN VALLEY ROAD		
GREEN '	VALLEY CARE CEN	ITER		I	LBANY, IN47150		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	F	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
IAG				IAG	alleged deficient practice, an none were found to be out of compliance. New facility prowill be for the Dialysis Center begin faxing the facility a repafter each visit to ensure communication between faci and center occurs. DON spowith the DON at FMC Dialysis center on 6/28/2011 and to Regional Coordinator with Dialysis on 6/29/2011 to notification of they agreed to assist and conwith request. Don or Design will complete weekly audits weeks and then monthly to ensure Dialysis Center communication sheets are received and filed appropriately. Results from the PI Committee Meeting for minimum of one year to ensure Dialysic Center sudits will be reviewed month.	etotocol rs to ort lity ke s avita fy and mply nee (4	DATE
	center. The information received from M 2011. Signed Ph indicated the residue.	the [named] dialysis rmation was for treatment ay 26, 2011 thru June 9, aysician Orders dated 6/11 ident was receiving thes a week since 1/30/11.			updated as indicated. After 1 if 100% compliance has not l achieved, the PI observation continue to be conducted mo and reviewed until 100% compliance has been achiev	been s will onthly	
	on 6/11/11 at 11: information from sent yesterday ev request. He wan the dialysis center	a the Director of Nursing 35 a.m., he indicated the in the dialysis center was vening at the facility ted the last two weeks, as er nor the EMS could find the binder. He wanted to					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155070		(X2) M A. BUII		NSTRUCTION 00	(X3) DATE	ETED	
		155070	B. WIN			06/10/2	011
	PROVIDER OR SUPPLIER		•	3118 GF	DDRESS, CITY, STATE, ZIP CODE REEN VALLEY ROAD BANY, IN47150	•	
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	DATE
	recreate the bind	er. Hours have been	İ				
	spent trying to lo	cate the book.					
	On 6/10/11 at 10	:20 a.m., the					
	Administrator pr	ovided the contract titled					
	"Nursing Home l	Dialysis Transfer					
	_	d April 24th, 2009 which					
	_	s not limited to, "Now,					
	therefore, the Ov	vner and Company agree					
	as follows: 2. ce	enter Obligations d. In					
	providing dialysi	s treatments to					
	Designated Resid	dents, Center shall adhere					
	_	nts of applicable state and					
	•	egulations, and shall					
		s and Procedures that					
		ty patient care, infection					
		cy care, proper waste					
	_	nance of equipment,					
	•	patient record keeping,					
	and patient safety						
	.	, -					
	On 6/10/11 at 12	:35 p.m., the					
		ovided the policy and					
	procedure for "N	• •					
	Practices" dated	•					
		s not limited to "Your					
	Health Informati						
		The Facility is required					
	-	privacy of your health					
	information."	1					
	On 6/10/11 at 1:4	15 p.m., the					
		ovided a copy of the					
		mbulance Services dated					
	<u> </u>						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M49M11

Facility ID: 000028

If continuation sheet

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PRINTED: 07/14/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155070	A. BUI			06/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	REEN VALLEY ROAD		
GREEN '	VALLEY CARE CEN	ITER		1	LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	JΈ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
	* '	which included, but was					
		Duties and Obligations					
	1	onfidentiality of Resident					
		ovider shall maintain					
	1	f all resident information					
		th any and all applicable					
	l ' '	other confidentiality					
	· ·	, rules, or guidelines,					
		(Health Insurance					
	1	ccountability Act of					
		nts and the prevailing					
	1	ales as established by the					
	1	rdance with the privacy					
		nall take reasonable steps					
		actions of its employees,					
		tes (as this term is					
	_	ivacy Rule) and all other					
	1 ^	om it has control comply					
		bligations under the					
		ovider shall execute a					
		Associate Agreement					
	with any of Provi						
	Associates prior	• •					
	protected health						
		Services to be provided					
	I -	uties and Obligations of					
	Facility. b. Reco						
	Facility shall (i) l						
		maintaining all resident					
	records, and (ii)n						
		ew and inspection the					
		nt treatment records					
	· ·	proper evaluation,					
	screening and tre	eatment of Facility's					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

M49M11 Facility ID:

000028

If continuation sheet

Page 36 of 39

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MI	JLTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155070	A. BUII	LDING	00	COMPL 06/10/2	
		193070	B. WIN			00/10/2	011
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
GREEN \	VALLEY CARE CEN	ITFR		1	REEN VALLEY ROAD LBANY, IN47150		
			_		1		(2/5)
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	residents as appro	opriate to Provider's					
	provision of Serv	-					
	-						
	On 6/10/11 at 1:4	15 p.m., the					
	Administrator inc	dicated neither the					
	dialysis center no	or the ambulance service					
	could find the blu	ue binder containing					
	confidential infor	rmation related to					
	Resident #109 an	d his treatment at the					
	dialysis center, w						
	communications	binder between the					
	facility and the co	enter.					
	3.1-50(d)						
E0000							
F9999							
	State Rule Findin	ng	F9	999	A copy of the		07/10/2011
		-6			Alzheimer's/Dementia Specia		
	3.1-4 NOTICE O	F RIGHTS AND			Care Unit Disclosure Form w		
	SERVICES				mailed to Residents residing that unit on 6/7/11. Resident		
					admitted to the		
	If the facility is re	equired to submit an			Alzheimer's/Dementia Specia	al	
	Alzheimer's and	dementia special care			Care Unit are subject to the alleged deficient practice. A	conv	
		orm under IC 12-10-5.5,			of the Special Care Unit	СОРУ	
	provide the reside	ent at the time of			Disclosure Form will be place		
	admission to the	facility with a copy of			the Facility Admission Binder		
	the completed Al	zheimer's and dementia			given to new admissions to t unit. Resident or Responsible		
	special care unit	disclosure form.			Party will be asked to sign th		
					they have received a copy of		
	This state rule was not met as evidenced by:				Disclosure Form. An audit w		
					conducted monthly by the HI Director to ensure a copy of		
					Alzheimer's/Dementia Specia	al	
	Based on intervie	ew and record review, the			Care Unit Disclosure Form w	/as	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING	00	COMPL	ETED
		155070	B. WIN			06/10/2	011
		<u> </u>			DDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIEF	₹			REEN VALLEY ROAD		
	VALLEY CARE CE	NTER		NEW AL	BANY, IN47150		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	•	TAG			DATE
	1	provide 3 of 6 residents			given to new admissions. Reference from the audit will be reviewed.		
	residing on the (the monthly PI Committee	o at	
		nentia & Alzheimer's Care			Meeting for a minimum of 1	/ear	
	_	of 24 a copy of the			to ensure 100% compliance.		
	Alzheimer's and	Dementia Special Care			100% compliance has not be		
	Unit disclosure f	form. (Residents #68, 88,			achieved, the audits will cont to be conducted monthly PI	inue	
	17)				Committee meeting until 100	ı%	
					compliance has been achiev		
	Findings include	:			Systems will be updated as		
					indicated.		
	1. The clinical r	ecord for Resident #68					
	was reviewed on	6/7/11 at 1100 a.m. The					
	resident was adn	nitted to the facility on					
		Alzheimer's unit with a					
	diagnosis of Alz	heimer and dementia.					
	Documentation						
		received a copy of the					
	· ·	eimer's and dementia					
	_	disclosure form.					
	special care unit	discressive form.					
	2. The clinical r	ecord for Resident #88					
	was reviewed on	6/8/11 at 10:55 a.m. the					
	resident was adn	nitted to the facility on					
	4/18/2011 to the	Alzheimer's and					
	dementia special	care unit with a					
		nentia with behaviors.					
	Documentation v						
		received a copy of the					
	1	eimer's and dementia					
	1 1	disclosure form.					
	special cure unit	GIOCIODAIO IOIIII.					
	3. The clinical r	ecord for Resident #17					
	was reviewed on	1 6/8/11 at 8:05 a.m. The					
	resident was adn	nitted to the facility on					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S	ETED	
		155070	B. WIN			06/10/2	011
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	•	
				1	REEN VALLEY ROAD		
	VALLEY CARE CEN			NEW A	LBANY, IN47150		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		Alzheimer's unit with a		IAG			DATE
	diagnosis of Alzh						
	Documentation v						
		eceived a copy of the					
	-	imer's and dementia					
	special care unit						
	-postar our ann						
	In interview with	the Administrator on					
	6/7/11 at 3:45 p.1						
	_	ere admitted to the					
		t had not received a copy					
	•	form. In interview with					
	Social Worker #2	2 at this time, she					
		es not provide the form to					
		lies and was not aware					
	they were to rece	eive the form.					
	-						
	On 6/10/11 at 9:5	55 a.m., the Administrator					
	provided a list of	28 current residents,					
	three of whom w	ere in the sample of 24,					
	admitted to the C	Garden Terrace Dementia					
	Care Unit from 9	0/1/2010 through					
	6/9/2011.						
	3.1-4(b)(11)						